LOS ANGELES COUNTY COMMISSION ON HIV

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July 13, 2005

To: Supervisor Gloria Molina, Chair
Supervisor Yvonne B. Burke
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: Craig A. Vincent-Jones, Executive Director
Commission on HIV Health Services

Subject: **ANNUAL RYAN WHITE CARE ACT PRIORITY- AND ALLOCATION-SETTING PROCESSES (YEARS 14 - 16)**

This memorandum will update you on the Commission on HIV's annual priority- and allocation-setting processes. The past County fiscal year (2004-2005) was a busy one for the Commission's Priorities and Planning (P&P) Committee in this regard, as it was engaged in priority- and allocation-setting from May 2004 – March 2005, concluding three full processes for Year 14 (March 2004 - February 2005), Year 15.(March 2005 - February 2006), and Year 16 (March 2005 - February 2007).

The 8.6% cut in the Year 14 (March 2004 – February 2005) Title I award required the Commission to revisit its Year 14 priorities and allocations, as it had not anticipated an award reduction of this size. Begun in May 2004 and completed in two phases by July 2004, the P&P Committee then immediately began priority- and allocation-setting in time for the Year 15 (March 2005 – February 2006) Title I application, completing that process in August 2004. The P&P Committee returned to priority- and allocation-setting activities in November 2004, as it implemented a new schedule for setting Year 16 (March 2006 – February 2007) priorities and allocations.

Following are the results from each of the three priority- and allocation-setting processes that the Commission, led by the P&P Committee, implemented over the course of the past fiscal year.

I. **Priority- and Allocation-Setting for Year 14 (March 2004 – February 2005):** The Commission revised its allocations for Year 14 corresponding to the Title I award reduction in two phases.

   A. **Phase One:** In Phase 1, the Commission cut 3% across all service categories, and 8% in planning council and program support. Additionally, the Office of AIDS Programs and Policies (OAPP) reduced its administrative and quality

management budgets by 8%. The Commission instructed OAPP to make the service cuts in accordance with the Geographic Estimate in Need (GEN), which resulted in greater reductions for some services in some Service Planning Areas (SPAs). Those cuts accounted for what the Commission estimated to be approximately half of the Year 14 Title I award reduction ($1.6 million).

The Commission, in concert with OAPP, intended to make up the remainder of the Title I award reduction through revenue enhancement strategies:

1. Reduce the amount of the reduction in the Alcohol and Drug Program Administration's (ADPA) substance abuse funding contribution to OAPP;
2. Enhance State funding through increased Title II contributions and/or prevention allocations, therein allowing OAPP to move more funding into the traditionally Title I-funded areas;
3. Restore the State-funded Therapeutic Monitoring Program (TMP) for viral load diagnostic assay testing.

B. Phase Two: As a contingency plan, the Commission approved further service cuts if the projected revenue enhancement strategies had been only partially or not at all successful. The service reductions were based on low-priority services, low service cost-effectiveness and/or the possible availability of other funding:

1. Defund hospice care (Title I funds = $166,000)
2. Reduce substance abuse by the same amount (0.5%)
3. Reduce medical outpatient care by the remaining amount needed (up to $1.2 million).

C. Results: All three revenue enhancement scenarios were successful to a certain extent:

1. ADPA reduced its reduction by more than $150,000;
2 State Title II consortium funding was increased by $300,000, and additional prevention funds were directed to the County;
3. TMP was restored in the State budget for $4 million (half of the original expenditure), reducing the cost of viral load vouchers to Los Angeles County by approximately $800,000 for the remainder of the program year.

As a result, while the Title I funding allocations to hospice care, substance abuse and medical outpatient care reflected the Phase Two (contingency plan) reductions, the actual services were restored with OAPP's NCC funds in light of the success of the revenue enhancement strategies.

II. <u>Priority- and Allocation-Setting for Year 15 (March 2005 – February 2006)</u>: After a month-long priority- and allocation-setting process comprising six P&P and one Finance Committee meetings, and more than 25 hours of Committee work involving more than a dozen Commissioners, the P&P Committee forwarded the following recommendations to the Commission. The Commission approved them on August

12, 2004 *(Attachment A is the Year 15 priority- and allocation-setting presentation the P&P Committee made to the Commission).*

A. **Contingency Plans and Multiple Funding Scenarios:** In order to avoid the rush of revised allocation decisions that the Commission had to make for Year 14 in response to the Title I award reduction, the P&P Committee agreed to make priority and allocation decisions in three distinct funding scenarios:
   1. Scenario #1: if Year 15 Title I award is increased, flat-funded or decreased by less than 4.9%;
   2. Scenario #2: if Year 15 Title I award is decreased by 5-9.9%; and
   3. Scenario #3: if Year 15 Title I award is decreased by 10% or more.

B. **Paradigms and Operating Values:** The P&P Committee selected, and the Commission later adopted, "paradigms" and operating values which serve as the guiding principles steering the decision-making for each of the three scenarios.

C. **Planning Council Support:** The Commission approved an allocation of 4% of the total Year 15 Title I award for planning council support (Commission budget).

D. **Program Support:** The Commission approved an allocation of 5% of the total Year 15 Title I award for program support and formed a subcommittee to review, evaluate and plan for program support expenditures in future years.

E. **Minority AIDS Initiative (MAI):** The Commission maintained its current MAI allocations of 79% for Medical Outpatient, 14% for Case Management, Psychosocial, and 2% Oral Health (5% is used for OAPP administrative costs) in Year 15, and formed a workgroup to review, assess and plan for future MAI allocations, expenditures and evaluation in subsequent years.

F. **Priorities and Rankings:** The P&P Committee approved the following priority rankings in each of three funding scenarios. Additionally, service categories and the accompanying allocations were altered in three significant ways:
   1. Medical outpatient, medical specialty, nutritional counseling and treatment adherence were combined;
   2. Pscychosocial and psychiatric mental health services were consolidated;
   3. Referral service category was eliminated with a subsequent directive that referral services should be—to the extent that they have not already been—incorporated into all service categories.

Table 1. YEARS 14 and 15 PRIORITY RANKINGS				
SERVICE CATEGORY	***Year 14 Priority***	***Year 15 Ranking Scen. #1***	***Year 15 Ranking Scen. #2***	***Year 15 Ranking Scen. #3***
Ambulatory/outpatient, medical + Ambulatory/outpatient, specialty + Nutritional counseling + Treatment adherence	Prior #1/High	1	1	1
Mental health services, psych + psychiatric	Prior #1/High	2	2	2
Oral health care	Prior #1/High	3	3	5
Housing assistance	Prior #2/High	4	4	8
Food bank/delivered meals/supplements	Prior #2/High	5	5	6
Transportation services	Prior #2/High	6	6	7
Case management, psychosocial	Prior #3/High	7	7	3
Case management, medical	Prior #3/High	8	8	4
Substance abuse services	Prior #1/High	9	9	9
Translation/interpretation	Prior #3/High	10	10	12
Legal services	Prior #4/Medium	11	11	10
Psychosocial support, HIV support	Prior #5/Medium	12	16	16
Client advocacy	Prior #2/Medium	13	12	14
Child care services	Prior #2/Medium	14	13	13
Permanency planning	Prior #4/Low	15	14	11
Residential or in-home hospice care	Prior #1/Low	16	15	15
Referral for health care/support	Prior #3/Low			

G. Rate Studies: The Commission reiterated its support for the rate study process, and their subsequent implementation once adopted, formally approving a recommendation to make allocation decisions in accordance with unit cost measures generated by the rate studies.

H. Service Allocations: The Commission approved the following allocations in each of the three funding scenarios, consistent with the priorities it established.

1. Scenario #1 *(If Year 15 Title I award is increased, flat-funded or decreased by less than 4.9%)*: The Commission supported OAPP recommendations by:
   a. increasing the allocation to Legal Services,
   b. clustering the Housing Assistance and Hospice allocations, and
   c. decreasing the Transportation allocation.

   Housing Assistance and Transportation allocations were decreased, in part, due to elimination of group home support and van transportation in those categories, respectively.

The allocations were developed in an effort to maintain funding levels in the remaining service categories proportionate to their funding levels in the prior year. That was accomplished by reviewing the dollar amounts, detailing those dollar amount goals, determining the gap to the prior year's award and the changes that were made for Year 15, applying that gap proportionately across those remaining service categories, and determining percentages of the total award once the gap had been applied. That process resulted in some percentage allocation shifts from the Year 14 allocations, when funds were cut due to the Title I award reduction.

Table 2. YEARS 14 and 15 SCENARIO #1 ALLOCATIONS

SERVICE CATEGORY	***Year 14 Allocation (%)***	***Year 15 Ranking***	***Year 15 Allocation (%)***
Ambulatory/outpatient, medical + Ambulatory/outpatient, specialty + Nutritional counseling + Treatment adherence	52.9%	1	55.3%
Mental health services, psych + psychiatric	9.6%	2	9.3%
Oral health care	2.4%	3	2.5%
Housing assistance	5.0%	4	4.7%
Food bank/delivered meals/supplements	2.2%	5	2.1%
Transportation services	4.0%	6	2.9%
Case management, psychosocial	10.9%	7	11.3%
Case management, medical	.8%	8	.7%
Substance abuse services	6.8%	9	6.5%
Translation/interpretation	.7%	10	.7%
Legal services	1.1%	11	1.2%
Psychosocial support, HIV support	1.6%	12	1.5%
Client advocacy	.6%	13	.6%
Child care services	.6%	14	.6%
Permanency planning	.1%	15	.1%
Residential or in-home hospice care	.5%	16	*Cluster w/ HA*
Referral for health care/support	.2%		
TOTAL* **	100.0%		100.0%

2. Scenario #2 *(if Year 15 Title I award is decreased by 5-9.9%)*: The Commission approved the application of the same percentages as in Scenario #1 across all of the service categories was appropriate, and applying the percentage reduction equally to each of the service categories.

Table 3. | YEARS 14 and 15 SCENARIO #2 ALLOCATIONS			
SERVICE CATEGORY	***Year 14 Allocation (%)***	***Year 15 Ranking***	***Year 15 Allocation (%)***
Ambulatory/outpatient, medical + Ambulatory/outpatient, specialty + Nutritional counseling + Treatment adherence	52.9%	1	55.3%
Mental health services, psych + psychiatric	9.6%	2	9.3%
Oral health care	2.4%	3	2.5%
Housing assistance	5.0%	4	4.7%
Food bank/delivered meals/supplements	2.2%	5	2.1%
Transportation services	4.0%	6	2.9%
Case management, psychosocial	10.9%	7	11.3%
Case management, medical	.8%	8	.7%
Substance abuse services	6.8%	9	6.5%
Translation/interpretation	.7%	10	.7%
Legal services	1.1%	11	1.2%
Psychosocial support, HIV support	1.6%	16	1.5%
Client advocacy	.6%	12	.6%
Child care services	.6%	13	.6%
Permanency planning	.1%	14	.1%
Residential or in-home hospice care	.5%	15	*Cluster w/ HA*
Referral for health care/support	.2%		
TOTAL* **	100.0%		100.0%

3. Scenario #3 *(If Year 15 Title I award is decreased by 10% or more)*: The Commission approved the following allocation strategy if the award is reduced by 10% or more:
   a. *Step #1*: Application of the Scenario #1 and #2 allocations across all service categories.
   b. *Step #2*: 10% cuts across all direct and non-direct service categories.
   c. *Step #3*: Further reductions up to 1% of the total allocated amount in planning council and program support, as appropriate.
   d. *Step #4*: In the case the cut is more than 10%, elimination of service category funding allocation by service category beginning with the lowest ranked service category and continuing up the ranking until the percentage amount above 10% has been accommodated.

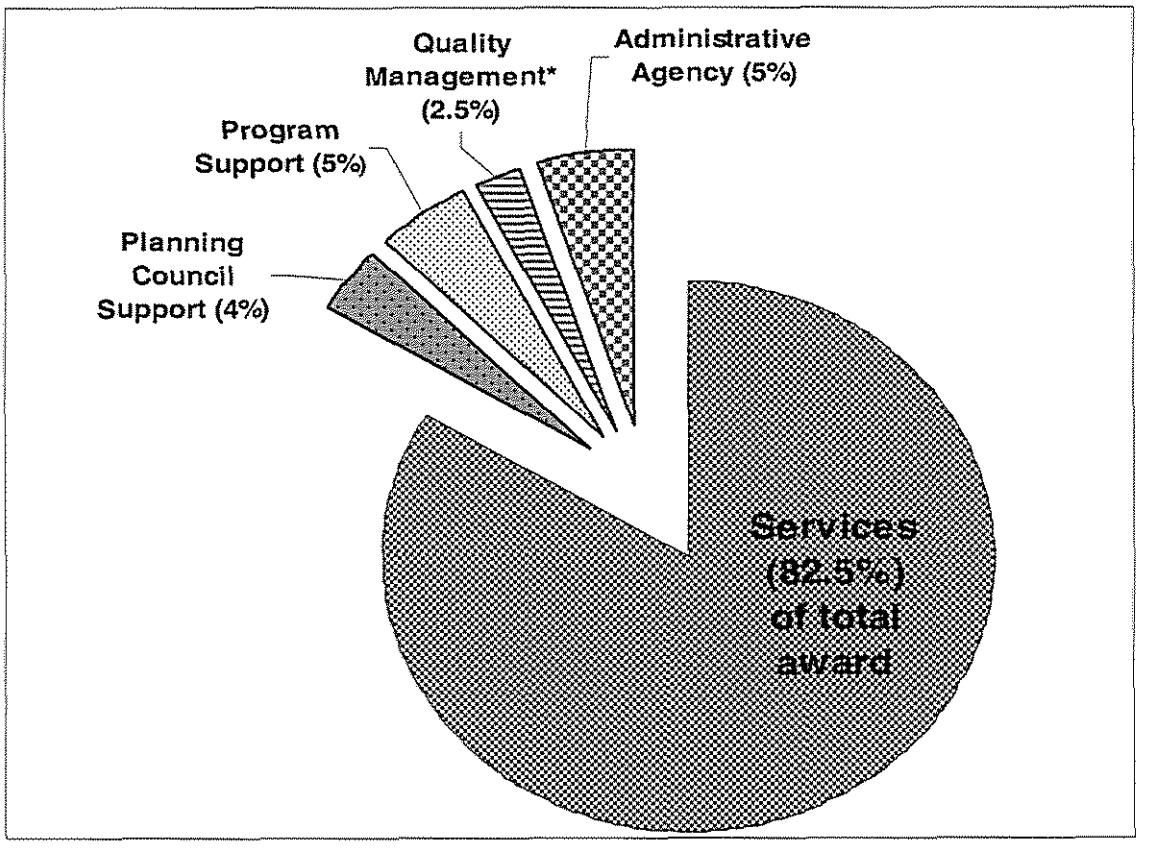
I. **Underspending**: The Commission adopted an underspending policy to be enacted in Year 14 and beyond: funds can be re-allocated during the year to the appropriate priority areas up to the following levels of that service priority's total allocation *(based on historical analysis of underspending reallocation trends)*:

- Priority #1: Up to 6% of the total allocation to that priority
- Priority #2: Up to 5% of the total allocation to that priority
- Priority #3: Up to 4% of the total allocation to that priority
- Priority #4: Up to 3% of the total allocation to that priority
- Priority #5: Up to 2% of the total allocation to that priority
- Priorities #6-#8 combined: Up to 1% of the total allocation to that priority

The Commission can impose limits on the underspent funds re-allocated to any specific category as it deems appropriate.

J. Pool of Funds Allocated: The following diagram details the actual proportions of funds that the Commission allocated. The Commission is responsible for allocating funds to services, program support and planning council support, but does not allocate funds for quality management nor the administrative agency budget. Office of AIDS Programs and Policy (OAPP) typically takes its maximum allowable allocation at 5%.

Figure1. YEAR 15 PROPORTION OF FUNDS ALLOCATED



III. Priority- and Allocation-Setting for Year 16 (March 2006 – February 2007):

A. Process Modifications: Following the Year 15 process, the P&P Committee begin implementing a Commission directive from several years prior: move the priority- and allocation-setting process to earlier in the program year in order to give OAPP a better opportunity to implement any changes resulting from the Commission's priority and allocation decisions within the following year.

The directive also instructed the Committee to "roll-out" the priority- and allocation-setting process over several months, rather than all in one month. This process modification was made to give Commission members and the community an opportunity to adequately absorb and comprehend all of the information and to comment and provide input during the course of the priority- and allocation-setting deliberations. As a result, the P&P Committee began the priority- and allocation-setting process for Year 16 in November 2004 and concluded it in March 2005.

Another innovation to the process resulted in shifting the allocation-setting role from the P&P to the Commission's Finance Committee in deference to each committee's respective expertise and authority for the Commission.

Attachments B and C outline the priority- and allocation-setting process that was implemented to accommodate these dual directives. In this new schedule and timeline, the provider and consumer communities are given ample voice, which is solicited throughout the process. In addition, a number of new tools were introduced into the process to help the Commissioners and the community make better, more comprehensive decisions.

B. Priority Recommendations: A change highlighted in the Year 16 priority-setting process relates to how priorities have been selected and ranked. In previous priority-setting processes, the Commission applied different priority rankings to multiple funding scenarios. Multiple priority rankings, however, contradict the priority-setting process as outlined in the Ryan White CARE Act Title I Manual. In that manual, the Health Resources and Services Administration (HRSA) indicates that services are prioritized and ranked based solely on consumer and service need.

Funding considerations are not meant to impact the decision-making until allocations are determined. In other words, the basic need for a service does not change regardless of what and how many resources are available to support it: for example, if consumers rank medical outpatient care as their primary service need, that primary need is not altered if funding to support primary health care is limited or ample.

It is often incorrectly believed that a service category's priority ranking then dictates how much funding will be allocated to that service category. Actually, funding (or "resource allocations" as defined in the Title I manual) rely not just on priority ranking, but other criteria as well—such as the availability of other funding or resources outside the Ryan White CARE Act system (e.g., Medi-Cal funded services for primary health care), cost effectiveness and/or modes of delivery.

As a result, beginning with the Year 16 priority- and allocation-setting process, the P&P Committee determines only one priority ranking, which was used by the Finance Committee during their allocation deliberations and applied in multiple funding scenarios. This shift in priority-setting practice is intended to reflect the Commission's prioritization of services within the continuum of care, regardless of how these services are funded or the extent of unmet "demand" for those services. The following table details the Year 16 priority ranking approved by the Commission:

Table 4. YEAR 16 PRIORITY RANKING

SERVICE CATEGORY	***Priority Ranking***
Ambulatory/outpatient, medical + Ambulatory/outpatient, specialty + Nutritional counseling + Treatment adherence + Mental health services, psych	1
Mental health services, psychosocial	2
Oral health care	3
Housing assistance	4
Case management, psychosocial	5
Transportation services	6
Food bank/delivered meals/supplements	7
Substance abuse services	8
Case management, medical	9
Legal services	10
Psychosocial support, HIV support	11
Child care services	12
Client advocacy	13
Permanency planning	14
Translation/interpretation	15
Residential or in-home hospice care	

The Commission also approved the following two modifications to the service category continuum of care—made prior to ranking the priorities:

1. incorporating mental health, psychiatry into medical outpatient services,
2. eliminating residential or in-home hospice care as a prioritized service category.

C. **Funding Scenarios:** The Commission determined four separate funding scenarios, for use by the Finance Committee in the allocation-setting portion of the process. The four funding scenarios are as follows:

1. Scenario #1: if the Year 16 Title I award is increased from Year 15 (*Increased Funding*);
2. Scenario #2: if the Year 16 Title I award is funded at the same level as Year 15 (*Flat Funding*);
3. Scenario #3: if the Year 16 Title I award is decreased by less than 5% (*Up to 5% in Decreased Funding*); and
4. Scenario #4: if the Year 16 Title I award is decreased by more than 5% (*5.1% of More in Decreased Funding*).

D. **Paradigms and Operating Values**: The Commission adopted decision-making paradigms and operating values to be applied in each of the four separate funding scenarios. The paradigms and operating values guide the Commission's decision-making to help ensure that decision-making participants are reviewing the issues from the same perspective, and moving the process with the same principles in mind. Attachment D details the paradigms and operating values the Commission selected.

E. **Allocations**. The Finance Committee made its allocation decisions in accordance with rankings set by the P&P Committee, assessed other available sources of funding, considered the paradigms and operating values while making decisions, and determined allocations in each of four funding scenarios.

Table 5. YEAR 16 TITLE I/II ALLOCATIONS BY FUNDING SCENARIO

SERVICE CATEGORY	Year 16 Priority Ranking	Scen #1	Scen #2	Scen #3	Scen #4
Ambulatory/outpatient, medical + Ambulatory/outpatient, specialty + Nutritional counseling + Treatment adherence + Mental health services, psych	1	58.1%	58.1%	58.1%	58.1%
Mental health services, psychosocial	2	6.5%	6.5%	6.5%	6.5%
Oral health care	3	2.5%	2.5%	2.5%	2.5%
Housing assistance	4	4.7%	4.7%	4.7%	4.7%

Case management, psychosocial	5	11.3%	11.3%	11.3%	11.3%
Transportation services	6	2.9%	2.9%	2.9%	2.9%
Food bank/delivered meals/supplements	7	2.1%	2.1%	2.1%	2.1%
Substance abuse services	8	6.5%	6.5%	6.5%	6.5%
Case management, medical	9	.7%	.7%	.7%	.7%
Legal services	10	1.2%	1.2%	1.2%	1.2%
Psychosocial support, HIV support	11	1.5%	1.5%	1.5%	1.5%
Child care services	12	.6%	.6%	.6%	.6%
Client advocacy	13	.6%	.6%	.6%	.6%
Permanency planning	14	.1%	.1%	.1%	.1%
Translation/interpretation	15	.7%	.7%	.7%	.7%
Residential or in-home hospice care					
Subtotal *(100% of all Service Dollars)*		100.0%	100.0%	100.0%	100.0%
Program Support	16	5.0%	5.0%	5.0%	5.0%
Planning Council Support	17	4.0%	4.0%	4.0%	4.0%
Quality Management	18	***to be determined by Administrative Agency***			
Administrative Agency	19	5.4%	5.4%	5.4%	5.4%
TOTAL *(all Title I/Title II Funds)*		100.0%	100.0%	100.0%	100.0%

1. Scenario #1 *(Increased Funding)*: See allocations above.
2. Scenario #2 *(Flat Funding)*: See allocations above.
3. Scenario #3 *(Up to 5% Decreased in Funding)*: Percentage decrease across all categories.
4. Scenario #4 *(5.1% or More Decreased in Funding)*: Percentage decrease across all categories up to a 7.5% decrease. Above a 7.5% decrease, program support and planning council support will consider an additional decrease of up to 1.0%, after which service category allocations will be eliminated beginning with the lowest ranked service category up until the gap in decreased dollars has been filled.

F. Minority AIDS Initiative (MAI) Funding: Percentage allocations for MAI funding was left intact from Year 15, in deference to the forthcoming MAI Subcommittee recommendations

G. Directives: The P&P Committee also noted issues raised during the priority-and allocation-setting process that needed further follow-up, and issued "directives" at the conclusion of the process to other Commission committees and stakeholders to address those concerns.

1. Referral Services:
   - *To Standards of Care (SOC) Committee:* ensure that referral services are addressed in all service categories.

- *To SOC*: each standard should also instruct providers who and to whom referrals should be made in what circumstances/scenarios.

2. Cultural Competency:
   - *To SOC*: define cultural competence and how it is addressed in each of the service categories.
3. Client Advocacy:
   - *To SOC*: clarify how client advocacy is different from treatment adherence, case management and peer support, and how it should be offered.
   - *To Program Support Subcommittee*: review and address whether HIV/LA Resource Directory should be paid for with program support funds rather than client advocacy funds.
4. Translation/Interpretation:
   - *To SOC*: define translation/interpretation services, and establish whether service standards should entail trainings/promotion of those services.
   - *To Program Support Subcommittee:* review and address whether services currently provided in translation/interpretation are more properly addressed by program support funds.
5. Oral Health:
   - *To SOC*: oral health standards should address/include medications not covered by ADAP, other sources.
   - *To SOC*: oral health standards should incorporate routine preventive care into oral health care services.
   - *To SOC*: standards should also address referrals between oral health providers and medical outpatient providers.
   - *To Finance and OAPP*: ensure that oral health care medications not covered by ADAP and other sources can be covered by CARE Act funds to the extent allowed by the standards.
   - *To Public Policy*: when determined, develop advocacy strategy to include non-covered medications on the State formulary(ies).
   - *To AETCs*: can oral health training incorporate education on additional medications/preventive care/referral communications.
6. Substance Abuse Transitional Housing:
   - *To SOC*: non-substance abuse and substance abuse transitional housing must be differentiated in the standards—substance abuse transitional housing should be substance-free; sober living and harm reduction models should be defined; staffing patterns must reflect the differences in those services.
7. Hospice Services:
   - *To SOC*: define the enhanced care involved in providing hospice care to people with HIV/AIDS from the provision of hospice care generally, and if the same standard of care can be met by "in-home" hospice care, etc.; methodology behind the reasoning for current hospice care service structure.

8. Medical Outpatient:
   - *To Public Policy*: begin strategizing how to advocate for inclusion of medications not currently covered by ADAP/Medi-Cal (and, as a result, covered by medical outpatient funding) to their formularies.
   - *To SOC*: ensure that preventive care and treatment adherence services are incorporated into Medical Outpatient care, and define acuity levels required for medical outpatient services.
   - *To Finance and Strategic Planning*: begin assessing the relationship between people accessing emergency care rather than availing themselves of ongoing, routine medical outpatient care, and frequency standards.

Please do not hesitate to contact me at 213.639.6714 if you have any questions or need additional information about any of these processes. Thank you for your time and attention to this matter.

Attachments (4)

c: Health Deputies
Executive Office, Board of Supervisors
Department of Health Services
Commission on HIV Health Services
Priorities and Planning (P&P) Committee
Lorenzo Taylor, Title I Project Officer
File

Los Angeles County

Commission on HIV Health Services

YEAR 15 TITLE I/II PRIORITY- AND ALLOCATION-SETTING PROCESS

August 12, 2004

from the Priorities and Planning (P&P) Committee

Outline

- Framework/Process
- Service Categories
- Needs Assessment
- Paradigms/Values
- Scenarios
- Priorities/Rankings
- Allocations
- Process Evaluation
- Motions

Framework/Process

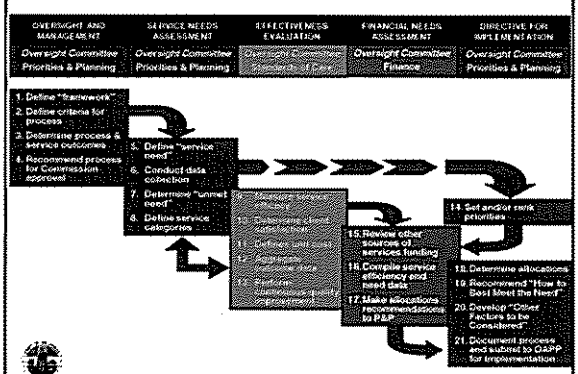
Presented by

Anna Long, Ph.D.
Member, Priorities and Planning (P&P) Committee

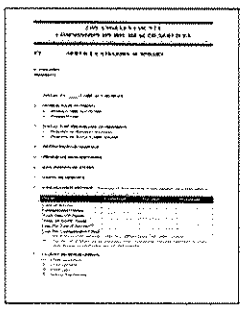
Framework/Process *(cont.)*

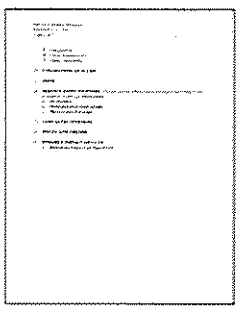
- Priority- and Allocation-Setting framework approved by Commission on January 8, 2004
- Service Category Summary Sheet format approved by Commission on July 8, 2004

Framework



Service Category Summary





Service Category Summary *(cont.)*

- Category, priority and past priority
- CARE Act and other funding
- Service definitions
- Key points of entry
- Units of service and cost effectiveness
- Service utilization: contrasted vs. provided
  - Costs per units and per clients
  - Variances of contracted vs. provided
- Client demographics
- Utilization analysis
- Expressed need, barriers and gaps
- Issues, trends and impacts

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Process

- P&P Committee, June 22, 2004 *(3 hours)*
  - original planning meeting
- P&P Committee, June 29, 2004 *(3 hours)*
  - scenarios
  - paradigms and operating values
- P&P Committee, July 6, 2004 *(3 hours)*
  - needs assessment
  - documented need
- P&P Committee, July 20, 2004 *(3 hours)*
  - service category summary sheets
  - service utilization data

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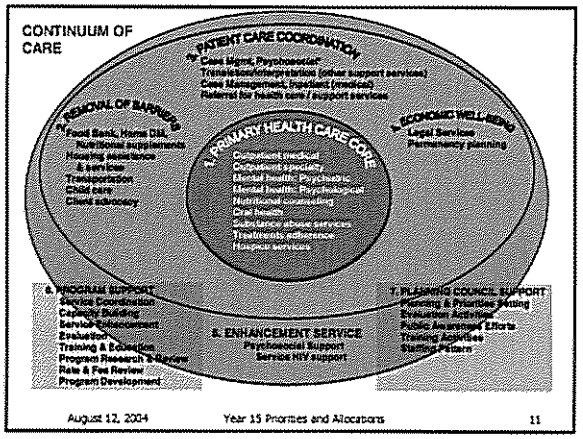
Process *(cont.)*

- P&P Committee, July 27, 2004 *(5 hours)*
  - priorities and rankings
- Finance Committee, July 29, 2004 *(5 hours)*
  - planning council support budget
  - allocations
- P&P Committee, July 30, 2004 *(3 hours)*
  - review and approval
  - directives

Service Categories

Presented by

Kevin Van Vreede
Member, Priorities and Planning (P&P) Committee



Primary Health Care

- **Ambulatory/Outpatient Medical, Medical**
  - Medical services provided by physician, physician assistant, clinical nurse or nurse practitioner in an outpatient, community- or office-based setting:
    - HIV/AIDS outpatient care including testing, early intervention, risk assessment, preventive care, medication management, and referral to and provision of specialty care.

	Contracted	Actual
Units of Service	135,600 7.31 services/client	104,177 6.62 services/client
Unduplicated Clients	18,578	15,731
Cost	$21,024,765	$19,571,269

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Primary Health Care *(cont.)*

- **Ambulatory/Outpatient Medical, Specialty**
  - Medical services including but not limited to cardiology; dermatology; ear, nose and throat; gastroenterology; gynecology; neurology; ophthalmology; oncology; pulmonary medicine; podiatry; proctology; general surgery and urology.

	Contracted	Actual
Units of Service	450 2.18 services/client	355 2.19 services/client
Unduplicated Clients	208	162
Cost	$544,624	$437,916

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Primary Health Care *(cont.)*

- **Oral Health Care**
  - Diagnostic, prophylactic and therapeutic services rendered by dentists, dental hygienists, and similar professional practitioners.

	Contracted	Actual
Units of Service	9,348 4.70 services/client	11,165 7.57 services/client
Unduplicated Clients	1,985	1,475
Cost	$696,720	$553,082

14

Primary Health Care *(cont.)*

- **Treatment Adherence Services**
  - Provision of counseling or special programs to ensure readiness for and adherence to complex HIV/AIDS treatments.
    - Goal of services is to provide HIV treatment education including up-to-date information about HIV and related illness, treatment options and available clinical trials.

	Contracted	Actual
Units of Service	10,644 3.99 services/client	12,956 5.23 services/client
Unduplicated Clients	2,668	2,475
Cost	$1,664,715	$1,521,892

15

Primary Health Care *(cont.)*

- **Substance Abuse Services (Outpatient/Residential)**
  - Provision of treatment and/or counseling to address substance abuse issues (including alcohol, legal and illegal drugs):
    - Includes residential detoxification, residential rehabilitation, day treatment, transitional housing, methadone maintenance and crisis counseling.

	Contracted	Actual
Units of Service	52,062 52.32 services/client	35,748 34.01 services/client
Unduplicated Clients	995	1,051
Cost	$2,389,794	$1,358,086

16

Primary Health Care *(cont.)*

- **Nutritional Counseling**
  - Provision of nutrition education and counseling by a licensed/registered dietitian outside of a primary care visit:
    - Includes screening for nutrition-related problems with a new diagnosis, with any status change, and at least every six months, with appropriate referrals to registered dietitians.

	Contracted	Actual
Units of Service	2,002 2.44 services/client	489 1.08 services/client
Unduplicated Clients	822	451
Cost	$208,063	$190,642

17

Primary Health Care *(cont.)*

- **Mental Health Services, Psychological**
  - Psychological and psychiatric treatment/counseling services provided by licensed mental health professionals, psychiatrists, psychologists, clinical nurse specialists, social workers and counselors:
    - Includes individual, group and family psychotherapy, drop-in psycho-educational groups, and crisis intervention.

	Contracted	Actual
Units of Service	42,639 5.92 services/client	32,159 8.53/ services/client
Unduplicated Clients	7,203	3,771
Cost	$2,422,647	$2,108,907

18

Primary Health Care *(cont.)*

- **Mental Health Services, Psychiatric**
  - Psychological and psychiatric treatment and counseling services provided by psychiatrist or psychiatric resident, or registered nurse or nurse practitioner under the direction of a psychiatrist:
    - Includes psychiatric assessment; diagnosis, treatment of mental disorders by psychotropic medications, and/or psychotherapy and crisis intervention.

	Contracted	Actual
Units of Service	9,668 4.01 services/client	9,329 3.74 services/client
Unduplicated Clients	2,410	2,498
Cost	$1,179,780	$932,481

19

Primary Health Care *(cont.)*

- **Hospice Care**
  - Room, board, nursing care, counseling, physician services, palliative therapy provided by a hospice to patients in the terminal stages of illness:
    - Includes Congregate Living Health Facility (CLHF) services to provide 24-hour inpatient care, and care in residential homes (non-institutional). CLHF inpatient care including residential services, medical supervision, 24-hour skilled nursing, supportive care, pharmacy and dietary services.

	Contracted	Actual
Units of Service	*not available*	*not available*
Unduplicated Clients	*not available*	5
Cost	*not available*	*not available*

20

Removal of Barriers

- **Transportation**
  - Transportation services provided to a client in order to access primary medical care or psychosocial support services; may be provided routinely or on an emergency basis:
    - Includes bus tokens/passes, taxi rides and van transportation.

	Contracted	Actual
Units of Service	9,912 8.93 services/client	10,180 25.64 services/client
Unduplicated Clients	1,110	397
Cost	$1,784,507	$1,604,453

21

Removal of Barriers *(cont.)*

- **Housing Assistance**
  - Short-term/emergency assistance to support temporary or transitional housing to assist in gaining/maintaining medical care; must be linked and certified as essential to medical/health care services:
    - Includes Residential Care Facilities for Chronically Ill (RCF-CI), AIDS Residential Facility (ARF), residential transitional housing, residential emergency housing, and group home services

	Contracted	Actual
Units of Service	44,925 96.20 services/client	47,669 114.64 services/client
Unduplicated Clients	467	416
Cost	$1,715,896	$2,104,120

22

Removal of Barriers *(cont.)*

- **Food Bank/Home-Delivered Meals**
  - Provision of food, meals or nutritional supplements in the form of 1) daily meals, 2) food bank services and counseling on proper nutrition, and/or 3) food vouchers:
    - Units of service are meals, grocery bags and/or vouchers and may include personal hygiene items and nutritional supplements

	Contracted	Actual
Units of Service	101,018 18.90 services/client	152,689 26.61 services/client
Unduplicated Clients	5,345	5,738
Cost	$760,993	$751,505

23

Removal of Barriers *(cont.)*

- **Child Care Services**
  - Non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care for client's child or child client.

	Contracted	Actual
Units of Service	5,494 36.15 services/client	2,936 23.68 services/client
Unduplicated Clients	152	124
Cost	$205,907	$175,565

24

Removal of Barriers *(cont.)*

- **Client Advocacy**
  - Assessment of individual need, provision of advice and assistance in obtaining medical, community, social, legal, financial, and other needed services. Advocacy does not involve coordination and follow-up on medical treatments.
    - Includes referral and bilingual benefits documents, consumer guides.

	Contracted	Actual
Units of Service	125,000	125,000
Unduplicated Clients	*not applicable*	*not applicable*
Cost	$205,907	$205,907

25

Patient Care Coordination

- **Case Management, Psychosocial**
  - Client-centered services linking clients with primary medical care, psychosocial and other services to ensure timely, coordinated access to health and support services, and continuity of care, including:
    - Intake, assessment of client's resources and needs; development/ implementation of individual service plan; linked referrals; follow-up/monitoring; and reassessments of the client's status/needs.

	Contracted	Actual
Units of Service	103,116 28.38 services/client	71,179 14.49 services/client
Unduplicated Clients	3,633	4,913
Cost	$4,129,011	$4,129,011

26

Patient Care Coordination *(cont.)*

- **Case Management, Medical**
  - Client-centered services linking clients with primary medical care, psychosocial and other services to ensure timely, coordinated access to health and support services and continuity of care, including:
    - Ongoing assessment of needs and personal support systems, and inpatient case management services to prevent unnecessary hospitalization or to expedite discharge.

	Contracted	Actual
Units of Service	5,253 2.13 services/client	*not available*
Unduplicated Clients	2,466	*not available*
Cost	$283,978	$218,988

27

Patient Care Coordination *(cont.)*

- **Translation/Interpretation Services**
  - Services to assist in accessing HIV/AIDS services:
    - American Sign Language interpretation for deaf and/or hard-of-hearing clients;
    - Asian-language interpretation and translation services for monolingual Asian language-speaking clients;
    - Spanish-language interpretation and translation for monolingual Spanish-speaking clients.

	Contracted	Actual
Units of Service	2,004 7.56/ services/client	2,321 16.01 services/client
Unduplicated Clients	265	145
Cost	$244,587	$237,188

28

Patient Care Coordination *(cont.)*

- **Referral Services**
  - Directs clients to a service in-person or through telephone, written, other forms of communication, including formal referrals by providers and case managers, and informal referrals by support staff, or as part of an outreach services program.
    - HIV/LA Resource Consumer Directories in English and Spanish, Provider Directories (PD) and HIV/LA Resource website

	Contracted	Actual
Units of Service	65,000	65,000
Unduplicated Clients	*not applicable*	*not applicable*
Cost	$68,636	$68,636

29

Economic Well-Being

- **Legal Services**
  - Attorney's services to help reduce the impact of debilitating economic conditions by providing legal advice, support and intervention necessitated by an individual's HIV/AIDS status:
    - Includes interventions to ensure client's access to/maintenance of primary health care, support services and eligible benefits; discrimination or breach of confidentiality litigation; and other matters related to the client's HIV/AIDS status.

	Contracted	Actual
Units of Service	4,500 3.33 services/client	5,404 4.80 services/client
Unduplicated Clients	1,350	1,127
Cost	$377,4977	$369,481

30

Economic Well-Being *(cont.)*

- **Permanency Planning**
  - Attorney's services to help reduce the impact of debilitating economic conditions by providing legal advice, support and intervention necessitated by an individual's HIV/AIDS status:
    - Includes, but is not limited to, attorneys petitioning for legal guardianship and adoption for children so that children will remain stable and supported after their parent's death.

	Contracted	Actual
Units of Service	800 10 00 services/client	732 9 39 services/client
Unduplicated Clients	80	78
Cost	$34,318	$34,318

31

Enhancement Services

- **Psychosocial Support Services, HIV Support**
  - Individual and/or group counseling, other than mental health counseling, provided to clients, family and/or friends by non-licensed counselors.
    - May include psychosocial providers, peer counseling/support group services, caregiver support/bereavement counseling, drop-in, benefits or nutritional counseling and/or education.

	Contracted	Actual
Units of Service	7,596 6 75 services/client	7,016 5 68 services/client
Unduplicated Clients	1,125	1,236
Cost	$557,992	$486,083

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Needs Assessment

Presented by

Mitchell Cohen, Ph.D.
Principal Investigator, HIV/AIDS Care Assessment Project (H-CAP)
Consultant, Partnership for Community Health

Data Review

- Epidemiological data provided by HIV Epidemiology Program.
- First report of HIV/AIDS Assessment Project (H-CAP) survey and focus group data.
- Summary of client data for IMACS/Casewatch.

Epidemiology

- People Living With AIDS (PLWA) – 17,971
- Estimated PLWH: *aware of status* – 26,960
- Estimated PLWH/A: *aware of status* - 44,613
- Estimated PLWH: *unaware of status* – 8,897
- Total Estimated PLWH/A – 53,828

as of 6/30/03

Epidemiology: AIDS *(cont.)*

- **Ethnicity:** 41% Latino; 31% Anglo; 25% African American; 2% API; 1% other
- **Behavioral Risk Group (BRG):** 68% MSM; 14% heterosexual; 10% IDU; 6% MSM/IDU; 2% other
- **Gender:** 13% female, 87% male
  - ➲ Females much more likely to be African American or Latino, and heterosexual

as of 6/30/03

Epidemiology: HIV/AIDS *(cont.)*

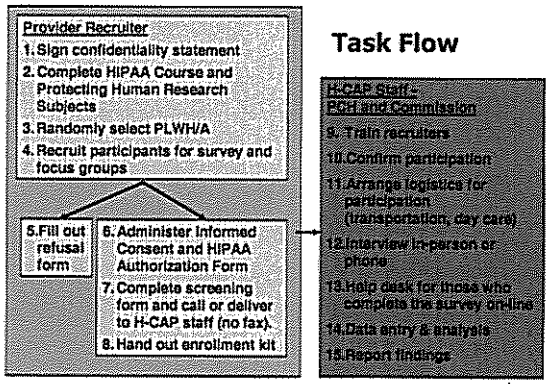
- African Americans represent 8.5% of the population and over 20% of PLWH/A and 30% of PLWH.
- Latinos represent about 46% of population, and 37% of PLWA and 44% of PLWH.
- Anglos represent approximately one-third of the population: 39% PLWA and 19% of PLWH.

as of 6/30/03

HIV Care Assessment Project

- H-CAP conducts a yearly survey and focus groups with PLWH/A measuring their needs, and barriers and gaps in HIV/AIDS services
  - About 825 of PLWH/A are interviewed annually.
  - Participants are asked to be in a panel that is re-interviewed yearly.
  - Changes in needs, barriers and gaps in services are analyzed over time.
  - Every year, there are 8 focus groups that explore special topics, each with approximately 12 participants.

Task Flow



H-CAP: Sampling

Risk Group	Anglo		African Am		Latino		API		Other/Mix		TOT.
	M	F	M	F	M	F	M	F	M	F	
MSM	50		50		70		35		10		215
MSM/IDU	40		20		30		10		0		100
IDU	30	25	50	45	20	25	10	5	0	0	210
HET	30	45	30	50	30	45	5	5	5	5	250
Transgender											25
American Indian											25
TOTAL	150	70	150	95	150	70	60	10	15	5	825

H-CAP: Survey

- **Questionnaire:** 60 – 90 minutes in-person, on phone or via Internet
- **Topics:**
  - Demographics, health history and stage of infection
  - Benefits and insurance
  - History of care, medication and adherence, prevention exposure
  - Co-morbidities, drug use
  - Service utilization and barriers
  - Service awareness, need, demand, utilization and satisfaction

H-CAP: Survey– Need Grid

Mental Health	A		B		C		D		E	
For each mental health service below...	Are you aware that the service exists?		Did you *need* this service in the past year?		Did you *ask for* this service in the past year?		Did you *receive* this service in the past year?		IF RECEIVED THE SERVICE, did this service *meet your* need?	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
10 Residential mental health services.	1	2	1	2	1	2	1	2	1	2
11 Individual mental health therapy or counseling sessions by a psychiatrist, psychologist, or social worker.	1	2	1	2	1	2	1	2	1	2

For the mental health services noted above, what problems did you experience in accessing or using the service? (SEE PROBLEM HANDOUT ON THE LAST PAGE OF THE QUESTIONNAIRE. WRITE IN PROBLEM OR USE LETTER BESIDE EACH PROBLEM ON THE PROBLEM HANDOUT.)

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H-CAP: Survey– Barrier Grid

Below is a list of problems that you may have had when trying to obtain or use HIV/AIDS services. Mark an X on the line beside each item to say how big a problem it has been for you. The line goes from a "very small" to a "very big" problem.

If you have not had the problem at all, circle "0".

A "very small" problem caused you minor concern and delays in obtaining the service(s).

A "moderate" problem means that you faced substantial problems but that you were able to get the service most of the time.

A "very big" problem means that it stopped you from getting the service(s).

	Not a problem	Very Small	Small	Mod-erate	Big	Very Big
p. I have been denied or have been afraid to seek services due to a criminal justice matter.	0					
q. Fear of my HIV or AIDS status being found out by others - lack of confidentiality.	0					

H-CAP: Response Rate

- First three months: 360 screening forms and more than 200 interviews.
- To date, refusal rate among those who completed screening sheets of less than 2%.
- Over three-quarters of the surveys conducted on the phone; 12% interested in in-person surveys; 10% interested in on-line surveys.

H-CAP: Respondents

	Est (6/03)	Goal Oversample	Survey (8/04)
Race/Ethnicity N=	44,613	825	210
Anglo	30.6%	27.6%	16.3%
African American	24.9%	30.7%	26.9%
Latino / Hispanic	40.8%	27.6%	40.4%
Asian/Pacific Islander	2.4%	6.8%	2.9%
Am Indian/Alaska Nat	0.6%	3.1%	3.8%
Other/NA	0.7%	2.5%	10.6%
Gender			
Male	86.6%	68.1%	75.5%
Female	13.4%	31.9%	24.5%

H-CAP: Analysis

- Gender
- Ethnicity/Race
- Stage of Infection
- Risk Groups
- Special Populations
  - Homeless
  - Undocumented
  - IDU/non-IDU Substance Users (also with MSM)
  - Mental illness: persistent and chronic
  - Women of child-bearing age (13-45)
  - MSM-MSM/W
  - Transgender
  - Recently incarcerated
  - Youth (13-19)

H-CAP: Focus Groups

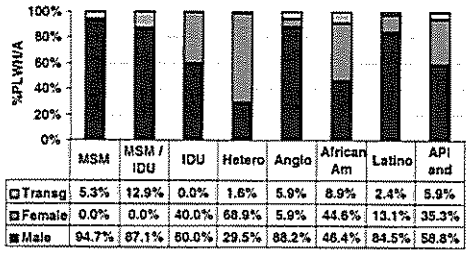
- 60- to 90-minute discussion groups in which members of high-risk populations address specific topics. In-depth topics in 2004 will be needs, gaps and barriers to accessing services by:
  - African Americans *(completed three groups)*
  - Latinos *(completed two groups)*
  - Out-of-Care *(completed one group)*
  - Men who have Sex with Men/Women *(completed one group)*

H-CAP: Group Outline

3. You are all **[FILL IN COMMON GROUP FEATURE]**. What groups or communities do you belong to? Do they affect the way you seek and receive HIV/AIDS Care?	Community
4. Just a show of hands – how many of you are in recovery or currently using substances? **(Moderator verbalize response)**	Substance use
5. Again, just hands, how many of you have had contact with prison or jail system in the past five or six years? **(Moderator verbalize response)**	Recently incarcerated
6. What are the most important HIV/AIDS services that you need to maintain or improve your health status? Do you receive it?	Service need

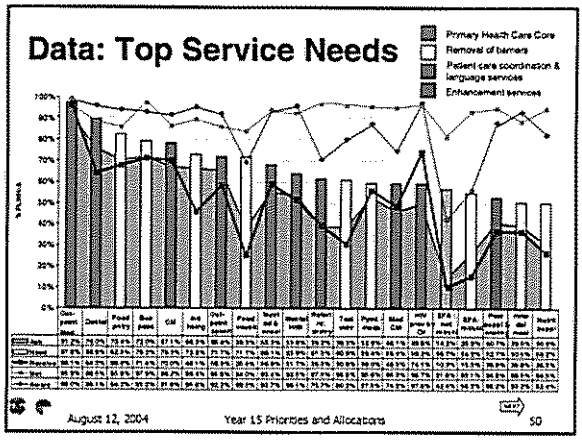
Data: Gender by Risk Group

N = 210 unweighted

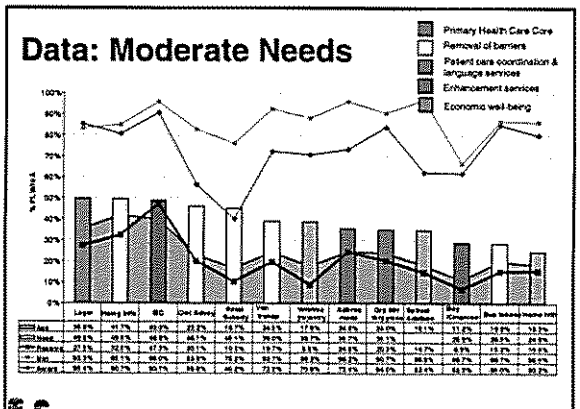


	MSM	MSM / IDU	IDU	Hetero	Anglo	African Am	Latino	API and
Transg	5.3%	12.9%	0.0%	1.6%	5.9%	8.9%	2.4%	5.9%
Female	0.0%	0.0%	40.0%	68.9%	5.9%	44.6%	13.1%	35.3%
Male	94.7%	87.1%	60.0%	29.5%	88.2%	46.4%	84.5%	58.8%

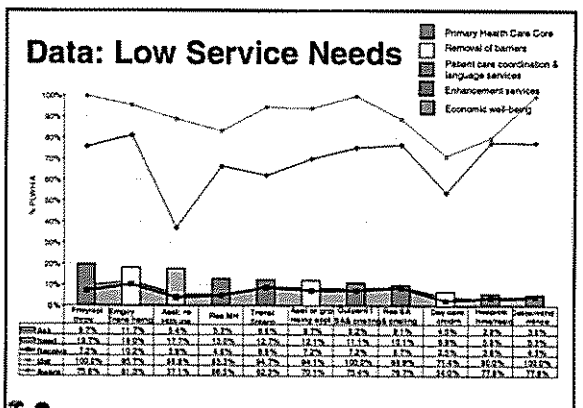
Data: Top Service Needs



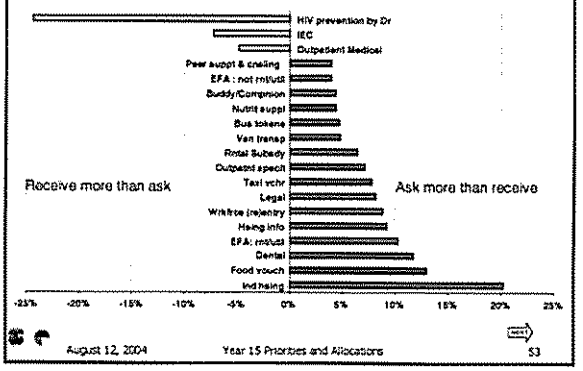
Data: Moderate Needs



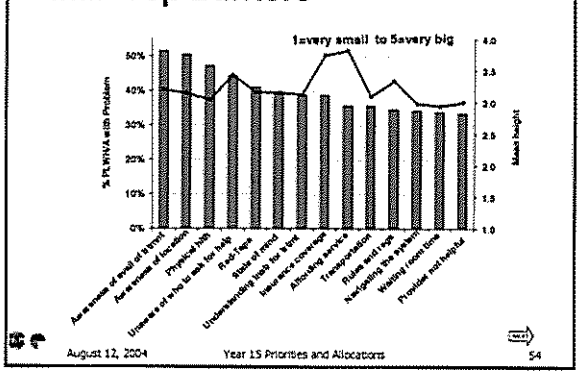
Data: Low Service Needs



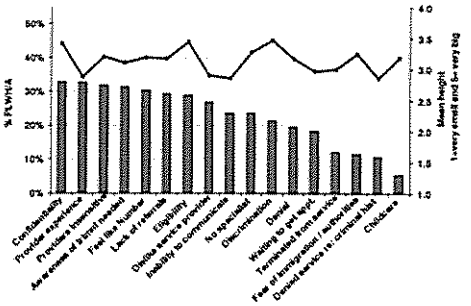
Data: Ask- Receive Gap



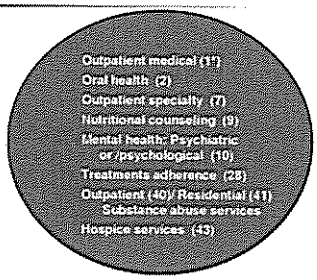
Data: Top Barriers



Data: Smaller Barriers



Primary Health Care Core



*Perceived need: 2004

Treatment Adherence

- 42% have never skipped their medication
- 32% report skipping their medication once or twice a month
- 9% report skipping their medication once or twice a week
  - Less than 1% report skipping their medication more than twice a week
  - 8% have stopped their medication
  - Among risk groups IDUs were more likely to skip their medication

Treatment Adherence *(cont.)*

- 8% say they were not prescribed medication
- Among Ethnic groups, African Americans were more likely to skip their medication
- Two top reasons for skipping medications:
  - 53% reported forgetting to take their medication (38% in 2002)
  - 26% reported side effects (22% in 2002)
- Compared to 2002 there are two notable differences:
  - Doctors advising patients not to take medication has declined
  - PLWH/A who didn't want other to see the medications declined

Mental Health

- For the purpose of this needs assessment mental illness is defined as having a diagnosis of anxiety, dementia, or depression
- 58% of PLWH/A report having been diagnosed with one of these conditions
- Individual therapy is perceived as the most needed mental health service with nearly 80% of the mentally ill PLWH/A reporting a need for this service

Mental Health *(cont.)*

- There is low demand for residential mental health services
- Individual therapy has the highest demand, with the severely mentally ill seeking this service more than other PLWH/A
- About 70% of mentally ill PLWH/A report receiving individual therapy, and about 30% receive group therapy
- There is no reported gap between those asking or and receiving licensed mental health services

Substance Abuse

- IDU and MSM/IDU account for about one quarter of the first phase of H-CAP compared to about 16% of all PLWH/A
- About one quarter of participants report a history of injecting drugs, but frequent use of heroin and crystal meth is low
- About 18% have used crack/cocaine in the last six months and 9% of PLWH/A say they continue to use the drugs more than once a week

Substance Abuse *(cont.)*

- Over one third of the PLWH/A say they have used crystal meth, about 7% report using it frequently (once a week or more)
- While more than 40% of PLWH/A are active substance users, less than 17% feel they have a need for treatment services
- Up to 13% of participants who are active substance users report asking for substance abuse services, and most report receiving services; there is little perceived gap in receiving substance abuse services

In-Home/Hospice Services

- Symptomatic PLWH/A account for 75% of the total sample, yet only about 26% of them feel they need home health care and about 6% feel they need hospice care
- 21% of symptomatic PLWH/A have sought home health care and 18% have receive the service
- A reported 3% of PLWH/A asked for hospice services and 4% received them

Removal of Barriers

Food bank (3),
Home-delivered meals (19),
Nutritional supplements (20)

Bus passes (4),
Taxi vouchers (12),
Van transportation (28),
Bus tokens (32)

Housing assistance (22)
Independent housing (6),
Emergency financial assistance-rent and utilities (17),
Rental subsidies (25)

Client advocacy (24)

Child care (42)

Housing Services

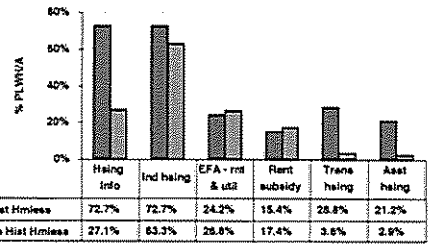
- In the 2004 needs assessment to date (N = 207), five PLWH/A are currently homeless, over 11% report transitional housing, 10% feel that their housing is unsafe, and 15% feel that their current housing is unstable
- PLWA (16%) express greater concern about the stability of their housing than PLWH (12%)
- PLWH/A with a history of homelessness tend to be more aware of housing services than other PLWH/A

Housing Services *(cont.)*

- However, PLWH/A with a history of homelessness are less likely to know about emergency financial assistance and rental subsidies—perhaps reflecting an actual lack of awareness, or eligibility constraints
- PLWH/A with a history of homelessness share of the same barriers to care as other PLWH/A. Yet, they are more impacted by their lack of insurance, transportation, and "red tape" than other PLWH/A

Housing Services *(cont.)*

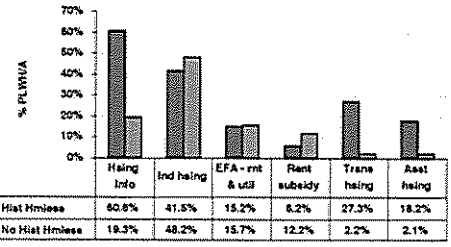
Asked for Housing



	Hsing info	Ind hsing	EFA - rnt & util	Rent subsidy	Trans hsing	Asst hsing
Hist Hmless	72.7%	72.7%	24.2%	15.4%	28.8%	21.2%
No Hist Hmless	27.1%	63.3%	26.8%	17.4%	3.6%	2.9%

Housing Services *(cont.)*

Received Housing



	Hsing info	Ind hsing	EFA - rnt & util	Rent subsidy	Trans hsing	Asst hsing
Hist Hmless	60.6%	41.5%	15.2%	6.2%	27.3%	18.2%
No Hist Hmless	19.3%	48.2%	15.7%	12.2%	2.2%	2.1%

Transportation

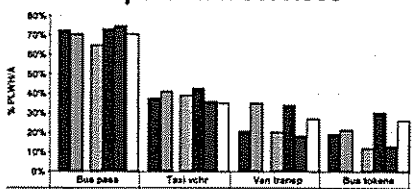
- More than 60% of the PLWH/A express a need for taxi vouchers and bus passes
- Bus passes rank as the 4th greatest need for all PLWH/A, and is the transportation with the greatest demand and utilization
- Taxi vouchers are rated by participants as the 12th greatest need
- The lack of transportation represents a moderate to big barrier of PLWH/A; also PLWH/As' comments convey the concern for the lack of funding of transportation services

Transportation *(cont.)*

- Needs , demand and utilization for transportation services is much higher among symptomatic PLWH/A
- Close to 60% of symptomatic PLWH/A ask for bus passes compared to 55% of asymptomatic PLWH/A
- The great need, demand and utilization for van transportation and bus tokens is among females and African Americans

Transportation *(cont)*

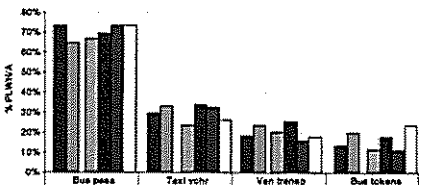
Asked for transportation services



	Bus pass	Taxi vchr	Van transp	Bus tokens
Male	72.4%	37.4%	20.8%	19.4%
Female	70.8%	41.2%	33.3%	21.0%
Anglo	64.7%	29.4%	20.8%	12.1%
Af Am	73.2%	42.9%	34.5%	20.4%
Latino	74.7%	36.1%	18.3%	13.3%
API	70.6%	35.3%	27.3%	26.5%

Transportation *(cont)*

Received transportation services



	Bus pass	Taxi vchr	Van transp	Bus tokens
Male	72.5%	29.7%	18.4%	13.6%
Female	64.7%	33.3%	23.5%	20.0%
Anglo	66.7%	23.5%	20.6%	11.8%
Af Am	69.6%	33.9%	25.5%	18.2%
Latino	73.5%	32.9%	18.0%	11.5%
API	73.5%	29.5%	18.2%	23.5%

Childcare

- "Day care for children in order for the parent or caregiver to receive HIV/AIDS services" was ranked among the lowest needs in 2004 (8%), 2002 (13%)
- Among women, the need doubles to 16%, but is still a relatively minor need, ranked 39th out of 44 service needs
- Among the 37 women in the 2004 sample, about 59% report having children that live with them; Latinas (78%) are more likely to have children with them than African Americans (59%), APIs (43%), or Anglo (0%); about 7% of the men report having children living with them

Patient Care Coordination

Case management, psychosocial (5)
Case management, medical (14)
Referral from HIV directory (11)

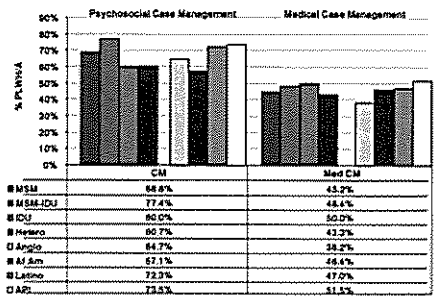
Case Management, Psychosocial

- Over three-quarters of those interviewed said they needed case management (CM); over two-thirds asked, about same percentage received
- MSM/IDU and Latinos are somewhat more likely to say they need CM
- Symptomatic participants are slightly more likely to report needing and asking for case management, but no more likely to receive it
- Those with and without insurance are equally likely to report needing CM, but those without insurance are less likely to receive it

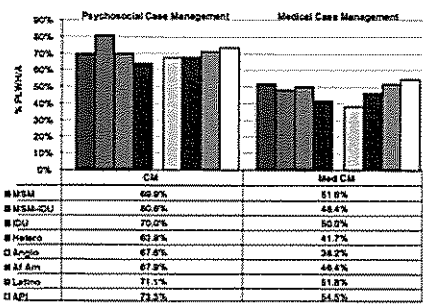
Case Management, Medical

- About a quarter of the participants said they didn't know about medical case management (MCM)
- About 60% said they need MCM, just under 50% said the ask for and receive it
- MSM/IDU and Latinos are somewhat more likely to say they need MCM
- Anglos are less likely to say they need MCM
- Symptomatic and non-symptomatic participants reported little difference in need, demand, or reported utilization of MCM

Case Management: Demand



Case Management: Received

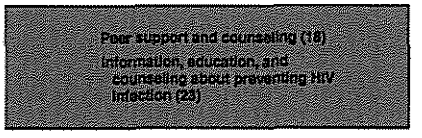


Economic Well-Being

Legal Services

- Legal services rank 21st out of 44 services in terms of client expressed need
- According to surveys received so far, legal services are needed and asked for more by MSM/IDUs and Anglos than other populations; also, according to current surveys MSM/IDUs, Anglos and APIs are most likely to receive legal services
- There is a moderate gap between those who ask for and those who receive legal care

Enhancement Services



HIV Peer Support

- Peer support and counseling is needed, asked for and received more by MSM/IDUs; IDUs have a higher than average need, but do not receive more of the service than any other group
- Latinos report that they have a greater need than other groups for information, education and counseling about preventing HIV infection; they say they ask for it more, and report that they get it more

Paradigms/Values*

Presented by

Kathy Watt
Member, Priorities and Planning (P&P) Committee

* *Thanks and appreciation to John D. Golenski, Ed.D., for use of his model of values-based priority and allocation decision-making*

Paradigms *(cont.)*

- **Morality:** represents a code of conduct or guide for decision-making in the context of consensus of beliefs
- **Ethics:** comprises the search for concrete decision-making guidelines when there are conflicts in morality or values
- **Values:** conflicts often arise when resources are limited or scarce
- **Benefits and Burdens** of each paradigm: no "correct" answers

Paradigms *(cont.)*

- **Justice Ethics:**
  - People have inherent equal rights
  - There are individual difference in capacity
  - Community must strive to equalize opportunity
  - Importance of rules of process
  - There are winners and losers

Paradigms *(cont.)*

- **Justice Ethics:**
  - Equality
  - Equity
  - Fairness
  - Rights and Duties
  - Compassion
  - Retributive Justice
  - Distributive Justice
  - Chance
  - Coercion
  - Utilitarianism
  - Altruism
  - Merit
  - Market
  - Fidelity

Paradigms *(cont.)*

- **"Caring" Ethics:**
  - Both need and capacity vary among individuals and over time
  - Community must strive to meet different needs
  - Community must take different capacities into account
  - Importance of complete inclusion

Paradigms *(cont.)*

- **"Caring" Ethics:**
  - Absolute Inclusion
  - Nuanced Inclusiveness
  - Risk Equalization

Values *(cont.)*

- Paradigms do not guarantee that the process of the decision will be or will feel "ethical"
  - *for example*, "consistent" with an individual's or a community's values
- Process (Operating) values are necessary for a "just" outcome

Values *(cont.)*

- **Operating Values:**
  - Openness or Transparency
  - Good Citizenship
  - Organizational Integrity
  - Contract Integrity
  - Beneficence
  - Non-maleficience
  - Survival
  - Quality of Care
  - Fidelity
  - Advocacy
  - Access
  - Representation
  - Efficiency

Scenarios *(cont.)*

1. **Scenario #1**: If the Year 15 Title I award is increased, flat-funded or decreased by less than 4.9%
2. **Scenario #2**: If the Year 15 Title I award is decreased by 5.0 – 9.9.%
3. **Scenario #3**: If the Year 15 Title I award is decreased by 10.0% or more

Scenario #1 *(cont.)*

- **Scenario #1**: If the Year 15 Title I award is increased, flat-funded or decreased by less than 4.9%
- **Paradigms:**
  - Equity
  - Fairness
  - Altruism
- **Values:**
  - Openness or Transparency
  - Access
  - Representation

Scenario #2 *(cont.)*

- **Scenario #2**: If the Year 15 Title I award is decreased by 5.0 – 9.9.%
- **Paradigms:**
  - Equity
  - Altruism
  - Distributive Justice
- **Values:**
  - Access
  - Efficiency
  - Quality of Care

Scenario #3 *(cont.)*

- **Scenario #3**: If the Year 15 Title I award is decreased by 10.0% or more
- **Paradigms:**
  - Utilitarianism
  - Altruism
  - Equity
- **Values:**
  - Access
  - Non-Maleficence
  - Efficiency

Priorities/Rankings

Presented by

Bradley Land
Co-Chair, Priorities and Planning (P&P) Committee

Priorities/Rankings *(cont.)*

- **Priorities**: The eight service/administrative clusters defined by the Continuum of Care:
  1. **Priority #1**: Primary Health Care Core
  2. **Priority #2**: Removal of Barriers
  3. **Priority #3**: Patient Care Coordination
  4. **Priority #4**: Economic Well-Being Measures
  5. **Priority #5**: Self-Enhancement Services
  6. **Priority #6**: Program Support
  7. **Priority #7**: Planning Council Support
  8. **Priority #8**: Quality Management
  9. **Priority #9**: Administrative Agency Support

Priorities/Rankings *(cont.)*

- **Ranking:** The importance of service categories to the total consumer population and to the Continuum of Care in numerical order from the most important to the least
- The P&P Committee "ranked" service categories in the three scenarios this year because:
  - HRSA expects EMAs to rank service categories
  - It will facilitate completion of this year's Title I application

Priorities/Rankings *(cont.)*

- Modifications made in three areas to service category prioritization and rankings:
  1. Medical outpatient, medical specialty, nutritional counseling and treatment adherence were combined into one category
  2. Psychological and psychiatric mental health services were consolidated into a single category
  3. Referral service category was eliminated with the expectation that the administrative agency will be directed to—to the extent that it has not already been done—incorporate referral services into all categories

SERVICE CATEGORY	*Year 14 Priority*	*Year 15 Rank Score #1*	*Year 15 Rank Score #2*	*Year 15 Rank Score #3*
Ambulatory/outpatient, medical + Ambulatory/outpatient, specialty + Nutritional counseling + Treatment adherence		1	1	1
Mental health services, psych + psychiatric		2	2	2
Oral health care		3	3	5
Housing assistance		4	4	4
Food bank/delivered meals/supplements		5	5	6
Transportation services		6	6	7
Case management, psychosocial		7	7	3
Case management, medical		8	8	8
Substance abuse services		9	9	9
Translation/interpretation		10	10	12
Legal services		11	11	10
Psychosocial support, HIV support		12	15	16
Client advocacy		13	12	14
Child care services		14	13	13
Permanency planning		15	14	11
Residential or in-home hospice care		16	15	15
Referral for health care/support				

Priorities/Rankings *(cont.)*

- Rankings were determined by findings from the needs assessment in accordance with the operating paradigms and values
- In Scenarios #1 and #2, few changes to the rankings were made

Priorities/Rankings *(cont.)*

- Rankings in Scenario #3 were adjusted in accordance with paradigms/values
  - Those services providing direct medical care to the most clients remained the most important
  - Those services ensuring the greatest number of clients access to primary health care became more important
  - Those services affecting the most people or services which could not be accessed elsewhere were considered higher priority
  - Services more directly impacting the Continuum of Care were ranked higher

Priorities/Rankings *(cont.)*

- The P&P Committee approved a resolution to adopt the implementation of service allocations in accordance with the adopted rate studies.
- As recommended in the rate studies, there are two practical implications:
  1. Van transportation will no longer be funded with Title I/II funds in the Transportation
  2. Group home services will no longer be funded with Title I/II funds in Residential

Priorities/Rankings *(cont.)*

- Van transportation was de-funded because:
  - Impacted, in the aggregate, few clients
  - Few agencies offer it, and few agencies can access it
  - Extremely low cost-effectiveness and cost-inefficiency
  - Among high cost/client and cost/service ratios
  - Unable to track outcomes and accompanying contribution to the Continuum of Care
- Van transportation service providers will be given time to modify their services accordingly

Priorities/Rankings *(cont.)*

- Group home services were de-funded because:
  - Very few clients accessing the services
  - Adequate funding is available through other sources [e.g., Department of Children and Family Services (DCFS)]

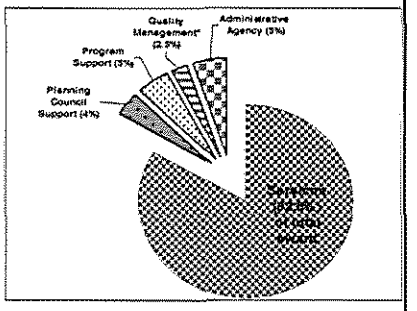
Allocations

Presented by

Carla Bailey
Co-Chair, Finance Committee
and
Andrew Ma
Co-Chair, Finance Committee

Allocations *(cont.)*

Year 15 Allocations*
(Quality Management allocation to be determined by Administrative Agency—Year 14's allocation used in this chart)



Other Streams of Funding

Priority #1:
Primary Health Care Core

Ambulatory/outpatient, early intervention	Title III, State
Ambulatory/outpatient, preventive care	State, CDC
Ambulatory/outpatient, patient education	*currently medical outpatient*
Ambulatory/outpatient, medical/specialty	County, Medi-Cal, VA, NCC
Drug reimbursement, State ADAP	State ADAP
Home health, professional care	Medi-Cal Waiver, State CMP
Mental health services, psychiatric/psychosocial	NCC, DMH, Medi-Cal, SAMHSA
Nutritional counseling	WIC (limited), Medi-Cal
Oral health care	Part F, County, Medi-Cal, VA

Other Streams of Funding *(cont.)*

Priority #1:
Primary Health Care Core *(cont.)*

Substance abuse services	ADPA, SAMHSA, State, housing
Treatment adherence services	various research studies
Drug reimbursement, medications	County, Medi-Cal, VA
Health education/risk reduction	CDC, State
Home health, specialized care	Medi-Cal Waiver, State CMP
Rehabilitation services	County, Medi-Cal, VA
Drug reimbursement, local	County
In-patient personnel costs	County
Residential or in-home hospice care	SSI, disability, Medi-Cal

Other Streams of Funding *(cont.)*

Priority #2:
Removal of Barriers

Food bank/delivered meals/supplements	GR, FEMA, WIC, Stamps
Housing assistance/services	HOPWA, LAHSA, NCC
Transportation services	MTA, Access, LA City, County
Child care services	LAFAN, WIC, Medi-Cal
Client advocacy	HOPWA
Emergency financial assistance	HOPWA
Outreach services	CDC, State

Other Streams of Funding *(cont.)*

Priority 3:
Patient Care Coordination

Case management, psychosocial	Medi-Cal Waiver, State CMP
Case management, medical	County, Medi-Cal, State CMP
Housing related services	HOPWA, LAHSA, NCC
Translation/interpretation	County
Referral for health care/support	HOPWA

Other Streams of Funding *(cont.)*

Priority 4:
Economic Well-Being Measures

Health insurance	CHIPS, CARE/HIPP, private
Legal services	LAC PD, Public Counsel
Workforce entry/re-entry	CalWorks, TANFF, GR
Child welfare services, family preservation	Childrens Services, DCFS
Child welfare services, foster care	Childrens Services, DCFS
Permanency planning	Public Counsel, Childrens Services, DCFS

Other Streams of Funding *(cont.)*

Priority 5:
Enhancement Services

Psychosocial support, HIV support	
Psychosocial support, pastoral care	private churches
Buddy/companion service	some agencies
Child welfare services, parenting education	DCFS
Day/respite care/adults	DCSS
Development assessment/children and infants	DCFS
Home health, para-professional care	Medi-Cal Waiver, State CMP
Psychosocial support, alternative services	
Psychosocial support, child abuse counseling	DCFS
Psychosocial support, recreational outings, caregiver support, bereavement	some agencies

Scenario #1/Paradigms

- **Scenario #1:** If the Year 15 Title I award is increased, flat-funded or decreased by less than 4.9%
- **Paradigms:**
  - **Equity:** relatively equal portions with attention paid to severe need
  - **Fairness:** similar cases treated in a similar fashion
  - **Altruism:** volunteering to take a cut or go without

Scenario #1/Values

- **Values:**
  - **Openness or Transparency:** decisional processes are not secret but open for all to witness and provide input
  - **Access:** ensuring clients' access to services in greater numbers or more effective ways
  - **Representation:** implementing decision-making in a way that includes people who adequately represent and/or reflect the need and diversity of the constituencies involved

Scenario #1/Allocations

SERVICE CATEGORY	Year 14 Allocation (%)	Year 15 Ranking	Year 15 Allocation (%)
Ambulatory/outpatient, medical + Ambulatory/outpatient, specialty + Nutritional counseling + Treatment adherence	52.9%	1	55.3%
Mental health services, psych + psychiatric	9.6%	2	9.3%
Oral health care	2.4%	3	2.5%
Housing assistance	3.0%	4	4.7%
Food bank/deliv/ered meals/supplements	2.2%	5	2.1%
Transportation services	4.0%	6	2.9%
Case management, psychosocial	10.9%	7	11.3%
Case management, medical	.8%	8	.7%
Substance abuse services	6.8%	9	6.5%
Translation/interpretation	.7%	10	.7%
Legal services	1.1%	11	1.2%
Psychosocial support, HIV support	1.6%	12	1.5%
Client advocacy	.6%	13	.6%
Child care services	.6%	14	.6%
Permanency planning	.1%	15	.1%
Residential or in-home hospice care	.5%	16	Consolidated
Referral for health care/support	.2%		
TOTAL	100.0%		100.0%

Scenario #1/Allocations *(cont.)*

- Allocation levels were shifted in three areas:
  1. The allocation level to Legal Services was increased
  2. The funds for Housing Assistance and Residential, In-home or Hospice Care were consolidated into one allocation, and, overall, it was decreased
  3. The allocation level to Transportation Services was decreased
- Other allocations were maintained at funding levels at the onset of the current year

Scenario #1/Allocations *(cont.)*

- **Legal Services increase:**
  - Legal services the only service category with an existing waiting list
  - The waiting list exists because the current provider is the only HIV specialty organization of its type in Los Angeles County, and other legal services usually refer clients when HIV is involved—whether they need to or not
  - Client goals and service provision is regularly exceeded
  - Growing number of undocumented clients facing challenges with HIV and residency

Scenario #1/Allocations *(cont.)*

- **Consolidation of Housing Assistance and Residential allocations:**
  - Both service categories with existing rate structures revised through the recent Residential/Substance Abuse rate study
  - Housing/Residential is a continuum of care that requires flexibility and services to follow the needs and progress of clients
  - Services in both categories very similar
  - Both types of services are governed by similar licensing and oversight bodies/organizations

Scenario #1/Allocations *(cont.)*

- **Housing Assistance/Residential decrease:**
  - Elimination of group home services reduces the need for funds dedicated to this service category
  - Reduce Hospice rates will reduce the need for funds dedicated to this service category
  - Several other funding sources paying for these services in the community

Scenario #1/Allocations *(cont.)*

- **Transportation decrease:**
  - Elimination of van transportation services reduces the need for funds dedicated to this service category

Scenario #1/Allocations *(cont.)*

- **Other allocations:**
  - Maintained other service category allocations proportionate to their funding levels at the onset of the current year
  - Percentage shifts occurred because proportionate allocations were made prior to current year cuts and modifications
  - Allocation shifts also resulted because the modified service categories (Legal, Housing, Transportation) were not included in the calculation

Scenario #2/Paradigms

- **Scenario #2:** If the Year 15 Title I award is decreased by 5.0 – 9.9.%
- **Paradigms:**
  - **Equity**: relatively equal portions with attention paid to severe need
  - **Altruism**: volunteering to take a cut or go without
  - **Distributive Justice**: working toward general equality

Scenario #2/Values

- **Values:**
  - **Access**: ensuring clients' access to services in greater numbers or more effective ways
  - **Efficiency**: accomplishing the desired operational outcomes with the least use of resources
  - **Quality of Care**: the highest level of competence in providing care

Scenario #2/Allocations

SERVICE CATEGORY	*Year 14 Allocation (%)*	*Year 15 Ranking*	*Year 15 Allocation (%)*
Ambulatory/outpatient, medical + Ambulatory/outpatient, specialty + Nutritional counseling + Treatment adherence	52.9%	1	55.5%
Mental health services, psych + psychiatric	9.6%	2	9.5%
Oral health care	2.4%	3	2.5%
Housing assistance	5.0%	4	4.7%
Food bank/delivered meals/supplements	2.2%	5	2.1%
Transportation services	4.0%	6	2.9%
Case management, psychosocial	10.9%	7	11.3%
Case management, medical	3%	8	3%
Substance abuse services	6.3%	9	6.5%
Translation/interpretation	.3%	10	.3%
Legal services	1.1%	11	1.2%
Psychosocial support, HIV support	1.6%	12	1.5%
Client advocacy	.6%	12	.6%
Child care services	.6%	13	.6%
Permanency planning	1%	14	1%
Residential or in-home hospice care	.5%	15	[illegible]
Referral for health care/support	.2%		
TOTAL	100.0%		100.0%

Scenario #2/Allocations *(cont.)*

- Only one priority alteration made between the lowest-ranked service categories
  - Hospice was upgraded to 15 from 16
  - HIV Support moved from 12 to 16
  - Other service categories between them were shifted accordingly, but order did not change
- **No allocation changes were made**
  - In consideration of the Scenario #2 paradigms and operating values, allocations applied in Scenario #1 were also appropriate in Scenario #2

Scenario #3/Paradigms

- **Scenario #3:** If the Year 15 Title I award is decreased by 10.0% or more
- **Paradigms:**
  - **Utilitarianism**: greatest good for the greatest number
  - **Altruism**: volunteering to take a cut or go without
  - **Equity**: relatively equal portions with attention paid to severe need

Scenario #3/Values

- **Values:**
  - **Access**: ensuring clients' access to services in greater numbers or more effective ways
  - **Non-Maleficence**: avoiding making the situation worse
  - **Efficiency**: accomplishing the desired operational outcomes with the least use of resources

Scenario #3/Allocations *(cont.)*

- In light of the Scenario #3 paradigms and operating values, and the resulting changes to the rank order, the Scenario #3 allocation strategy was altered further

Scenario #3/Allocations *(cont.)*

- A three-step implementation, depending upon the size of the cut:
  1. **Step #1**: 10% cuts across all categories (direct and non-direct services)
  2. **Step #2**: Further reductions up to 1% of the total allocated amounts in Program and Planning Council support, as needed and appropriate
  3. **Step #3**: Elimination of the service category funding allocation by service category beginning with the lowest-ranked service category

Underspending

- **Recommendation from OAPP**: for Year 14 and beyond, underspent funds can be reallocated to the appropriate priority areas up to the following levels of that service priority's total allocation:
  1. **Priority #1**: Up to 6% of total allocation
  2. **Priority #2**: Up to 5% of total allocation
  3. **Priority #3**: Up to 4% of total allocation
  4. **Priority #4**: Up to 3% of total allocation
  5. **Priority #5**: Up to 2% of total allocation
  6. **Priorities #6-8**: Up to 1% of total allocation

Underspending *(cont.)*

- Both the P&P and Finance Committees approved the recommendation:
  - It allows the administrative agency to continue maximizing the Title I/II grants—and not risk carry-over balances at the end of the year—which could lose the EMA application points
  - Gives the administrative agency greater flexibility to put the funds to greatest use in accordance with Commission's directives
  - Underspent funds would continue to be dedicated to areas of highest priority or funding need

Underspending *(cont.)*

- Underspending recommendation *(cont.)*:
  - The strategy is based on the historical analysis of how underspent funds have been re-allocated in this EMA
  - The Commission's underspending decisions have tended to be made last-minute without significant forethought or consideration
  - The Commission is <u>not</u> abdicating or ceding responsibility over allocation decisions because it will continue to be able to impose limits on the underspent funds re-allocated to any specific category as it deems appropriate.

Process Evaluation

Presented by

Bradley Land
Co-Chair, Priorities and Planning (P&P) Committee

Process Evaluation *(cont.)*

- Current Process Successes:
  - Use of new Service Category Summary Sheets as a data-sharing/communication tool
  - Along with implementation of the Summary Sheets, implementation of a new methodology for compiling all of the relevant information
  - While there are many areas in which implementation of the framework must be improved, this was the first year the framework was implemented
  - Much more comprehensive data/information used than in prior years

Process Evaluation *(cont.)*

- Current Process Successes *(cont.)*:
  - First year that the Finance Committee set allocations
  - Addressing paradigms and operating values played pivotal role and helped significantly
  - H-CAP data exceeded quality of prior years' need assessment data
  - Conducted a process evaluation at the conclusion

Process Evaluation *(cont.)*

- Current Process Areas for Improvements:
  - Process, while intense, was expedited and required too short of a timeline
  - Absence of service effectiveness assessments
  - H-CAP findings are only preliminary, so needs assessment information is more limited than desired
  - Provider input into the priority- and allocation-setting process not integrated into information
  - While more people participated than in past years, still too few participants

Process Evaluation *(cont.)*

- Improvements Planned for Next Year:
  - Year 16 Priority- and Allocation-Setting will begin in 11/2004 and run through 3/2005: *a four-month process*
  - First year of H-CAP will be completed, and findings available from 800+ surveys and focus group interviews
  - Year 13 Service Category Summary Sheets will be finalized, and Year 14 Service Category Sheets begun making data compilation an on-going continuous process

Process Evaluation *(cont.)*

- Improvements Planned for Next Year *(cont.)*:
  - Community will be regularly notified of the process steps and timeline so that they can join in the process
  - Provider input forms will be sent to all providers eliciting their comments and feedback about priority- and allocation-setting
  - Standards of Care (SOC) Committee will begin reviewing a single service category monthly
  - P&P Committee will begin asking for regular presentations from Service Provider Networks

Process Evaluation *(cont.)*

- Improvements Planned for Next Year *(cont.)*:
  - Provider forums will be conducted
  - In collaboration with OAPP, "Attachment Es" will be sent to providers to collect needed information about other sources of funds
  - New staff using Service Category Summary Sheets will begin collecting information about all services, not just those funded by Title I/II
  - Although, it will not be implemented yet, SOC will begin designing a methodology for the evaluation of service effectiveness

Process Evaluation *(cont.)*

- Improvements Planned for Next Year *(cont.)*:
  - Resource inventories will be created and tracked, especially in concert with HIV/LA Resource Directory
  - Staff will begin researching sources of documented need more thoroughly
  - "Change" and "Comparability" matrices will be introduced as decision-making tools
  - Formation of MAI and Program Support task forces to review, assess and plan activities for each purpose

Motions

Presented by

Nettie DeAugustine
Co-Chair, Commission on HIV Health Services

Motion #5 *(cont.)*

- Approve the priority rankings, as presented, in each of three funding scenarios. Service categories, as a result, are altered in three different ways:
  1. Medical outpatient, medical specialty, nutritional counseling and treatment adherence combined into one category;
  2. Psychosocial and psychiatric mental health services consolidated into a single category.
  3. Referral service category eliminated with the expectation that a directive that referral services should be—to the extent that they have not already been—incorporated into all service categories.

Motion #6 *(cont.)*

- Approve an allocation of 5% for Year 15 Program Support, consistent with plans to form a workgroup to review, assess and plan for Program Support expenditures.

Motion #7 *(cont.)*

- Approved a Year 15 Minority AIDS Initiative (MAI) allocation of 79% for Medical Outpatient, 14% for Case Management, Psychosocial, and 2% Oral Health, consistent with plans to form a workgroup to review, assess and plan for future MAI allocations, expenditures and evaluation.

Motion #8 *(cont.)*

- Adopt the implementation of service allocations in accordance with the adopted rate studies.

Motion #9 *(cont.)*

- Approve the allocations in each of the three funding scenarios, as presented, consistent with the priorities established by the Priorities and Planning (P&P) Committee.

Motion #10 *(cont.)*

- For Year 14 and beyond, approve a policy that underspent funds can be re-allocated during the year to the appropriate priorities up to the following levels of the priority's allocation:
  1. **Priority #1**: Up to 6% of total allocation;
  2. **Priority #2**: Up to 5% of total allocation;
  3. **Priority #3**: Up to 4% of total allocation;
  4. **Priority #4**: Up to 3% of total allocation;
  5. **Priority #5**: Up to 2% of total allocation;
  6. **Priorities #6-8**: Up to 1% of total allocation;

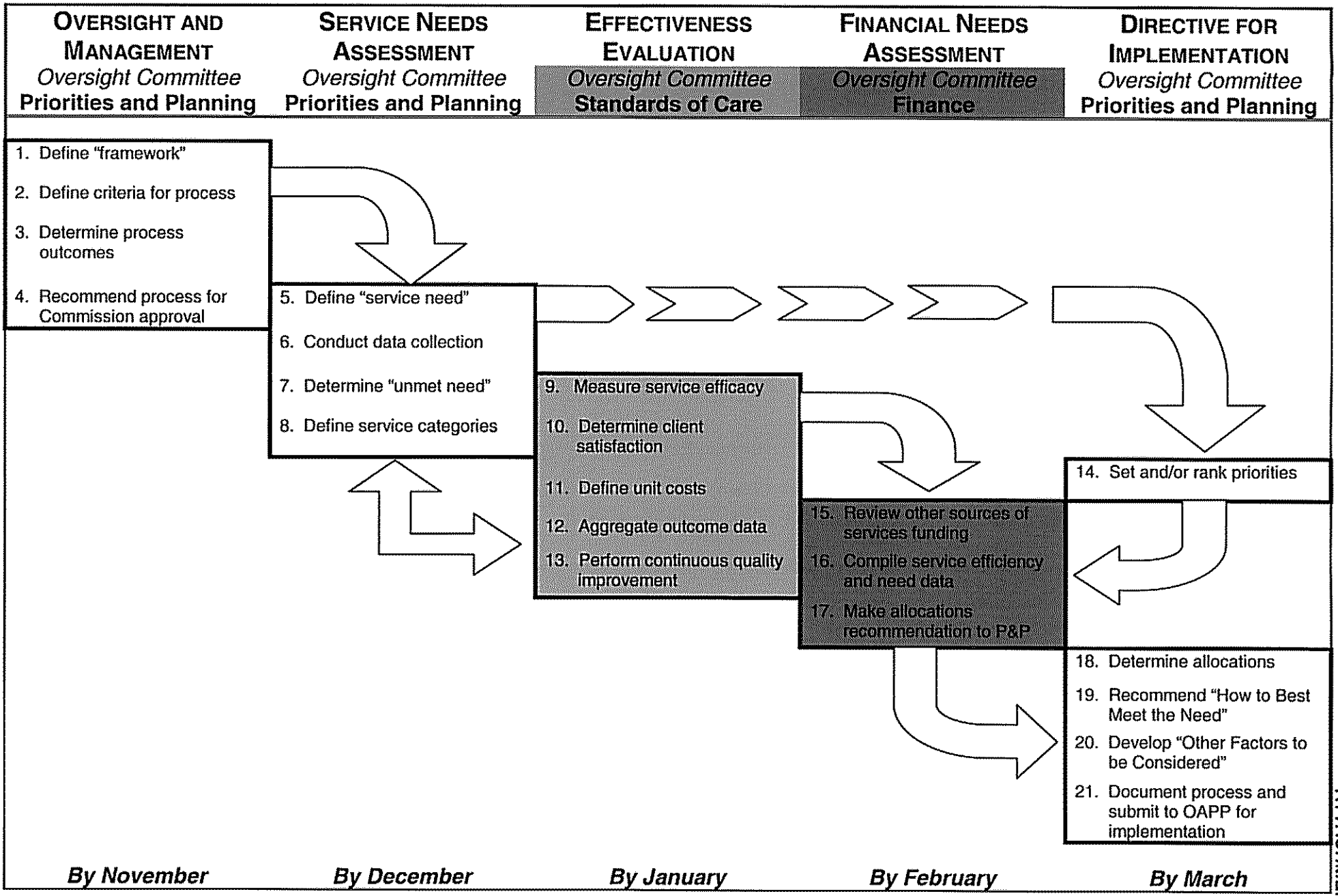
The Commission can impose limits on the underspent funds re-allocated to any specific category as it deems appropriate.

Reference

These slides will be available at
* www.hivcommission-la.info
or contact the Commission at
(213) 738-2816

* *Still under construction*

PRIORITY- AND ALLOCATION-SETTING (P&A) PROCESS



ATTACHMENT B

YEAR 16 PRIORITY- AND ALLOCATION-SETTING TIMELINE

November 04

- **P&P Committee** recommends P- and A-Setting process to **Executive Committee**
- **P&P** implements P- and A-Setting framework
- **Finance Committee** and **OAPP** collaborate on "Attachment E" (other streams of funding): forms finalized and sent to providers
- **P&P** sends public notices for participation in the process (all meetings)
- **P&P** selects paradigms and operating values
- **P&P** begins Service Category Summary Sheets (Year 13 sheets finalized; Year 14 sheets begun)

December 04

- **P&P** presents P- and-A Setting process report to Commission
- **Commissioners** sign pledges to participate in process
- **P&P** begins collecting provider input on service categories
- **Consultant** presents needs assessment analysis to **P&P**
- **Finance** develops Resource Inventory
- **SOC Committee** assembles information on unit cost, cost effectiveness and service effectiveness
- **HIV Epi** presents semi-annual Epi report to **Commission**

January 05

- **Consultant** presents needs assessment to **Commission**
- **P&P** and **OAPP** finalize Service Category Summary Sheets, incorporating all input
- **P&P** conducts provider forums
- **P&P** finalizes all public and provider input
- **Staff** completes special population analyses and **P&P** reviews
- **P&P** applies Change and Comparability matrices
- **P&P** sets priorities

February 05

- **P&P** presents Service Category Summary Sheets and Priorities to **Commission**
- **Commission** approves priorities
- **Finance** analyzes Attachment Es
- **Finance** reviews other sources of funding
- **Finance** completes Resource Inventory
- **MAI** and **Program Support** workgroups present final recommendations
- **Finance** reviews final PC budget draft
- **Finance** determines allocations

March 05

- **Finance** presents allocations to Commission
- **P&P** and **Finance** present to directives to "Best Meet the Need" and "Other Factors to be Considered" to Commission
- **Commission** approves directives and allocations

Year 16 Priority- and Allocation- Setting
-TIMELINE-

NOVEMBER 2004	**P&P** recommends Priorities- and Allocations- Setting process to **Executive Committee.**	November 1, 2004
	P&P initialed P- and A- Setting framework.	November 18, 2004
	P&P selects paradigms and operating values for process.	November 18, 2004
	Finance Committee and **OAPP** meet to collaborate on "Attachment E" (other streams of funding forms for providers to complete).	November 22, 2004
	P&P begins Service Category Summary Sheets (Year 13 sheets finalized; Year 14 sheets begun) Memo to OAPP requesting service utilization information.	November 30, 2004
	P&P sends public notices for participation in the P- and A- process (all meetings).	November 30, 2004
DECEMBER 2004	**SOC Committee** assembles information on unit cost, cost effectiveness and service effectiveness.	December 2, 2004
	Finance Committee and **OAPP** send out to providers "Attachment E" (other streams of funding forms for providers to complete).	December 3, 2004
	P&P sends request for provider input on service categories.	December 6, 2004
	Commissioners sign pledges to participate in the process.	December 9, 2004
	HIV Epidemiology Program presents semi-annual Epidemiology report to **Commission.**	December 9, 2004
	P&P presents P- and A- Setting process report to the Commission.	December 9, 2004
	Consultant to have entered needs assessment data on Service Category Summary Sheets.	December 10, 2004
	Consultant presents needs assessment to **P&P.**	December 14, 2004
	Finance Committee develops Resource Inventory.	December 17, 2004
	OAPPs service utilization data due.	December 30, 2004

ATTACHMENT C

Year 16 Priority- and Allocation- Setting
-TIMELINE-

JANUARY 2005	**P&P** conducts provider forum in Service Planning Area - 2	January 6, 2005
	Attachment E's due from **Providers.**	January 7, 2005
	P&P conducts provider forum in Service Planning Area - 6	January 11, 2005
	P&P conducts provider forum in Service Planning Area - 1	January 12, 2005
	Consultant presents needs assessment to **Commission.**	January 13, 2005
	P&P conducts provider forum in Service Planning Area - 4	January 14, 2005
	P&P applies Change and Comparability matrices.	January 18, 2005
	P&P sets priorities.	January 18, 2005
	Staff completes special population analysis and **P&P** reviews this information.	January 18, 2005
	P&P conducts provider forum in Service Planning Area - 8	January 19, 2005
	P&P and **Commission Staff** finalize Service Category Summary Sheets, incorporating all input.	January 20, 2005
	P&P conducts provider forum in Service Planning Area - 3	January 20, 2005
	P&P conducts provider forum in Service Planning Area - 5	January 27, 2005
	P&P conducts provider forum in Service Planning Area - 7	January 28, 2005
	P&P finalizes all public and provider input.	January 31, 2005

FEBRUARY 2005	**Commission** approves priorities.	February 10, 2005
	P&P presents Service Category Summary Sheets and priorities to the Commission.	February 10, 2005
	MAI and **Program Support** workgroups present final recommendations to the P&P Committee.	February 15, 2005
	Finance analyzes other streams of funding from providers during their February Committee meeting.	February 18, 2005
	Finance completes Resource Inventory during their February Committee meeting.	February 18, 2005
	Finance determines allocations during their February Committee meeting.	February 18, 2005
	Finance reviews final PC budget draft during their February Committee meeting.	February 18, 2005
	Finance reviews other sources of funding during their February Committee meeting.	February 18, 2005

Year 16 Priority- and Allocation- Setting
-TIMELINE-

MARCH 2005	**Commission** approves directives and allocations.	March 10, 2005
	Finance presents allocations to Commission.	March 10, 2005
	P&P and **Finance** present directives to "Best Meet the Need" and "Other Factors to be Considered" to Commission.	March 10, 2005

LOS ANGELES COUNTY
COMMISSION ON HIV HEALTH SERVICES

3530 Wilshire Boulevard, Suite 1140 ▪ Los Angeles, CA 90010 ▪ TEL (213) 738.2714 ▪ FAX 213.637.4748

December 9, 2004

To: Commission on HIV Health Services

From: Priorities and Planning (P&P) Committee

Subject: **PRIORITY- AND ALLOCATION-SETTING PARADIGMS AND OPERATING VALUES**

Utilizing the same methodology from the most recent Priority-and Allocation Setting (P-and-A) process, the Priorities and Planning (P&P) Committee has chosen paradigms and operating values for decision-making to help guide the Year 16 P-and-A process. The Committee selected from among the range of ethical paradigms and operating values described in further detail in Attachment A.

The P&P Committee choose decision-making paradigms and operating values for the following four funding scenarios:

I. Increased Funding
II. Flat Funding
III. .1-5% Decrease in Funding
IV. 5.1% or more Decrease in Funding

Following are the three paradigms and two- three operating values being recommended:

Paradigms:

Scenario I, Increased Funding
Equity: relatively equal portions with attention paid to severe need
Utilitarianism: greatest good for the greatest number
Distributive Justice: working toward general equality

Scenario II, Flat Funding
Equity: relatively equal portions with attention paid to severe need
Equality: equal portions to each or equal cuts
Fairness: similar cases treated in a similar fashion

Scenario III, .1-5% Decrease in Funding
Fairness: similar cases treated in a similar fashion
Distributive Justice: working toward general equality
Altruism: volunteering to take a cut or go without

Scenario IV, 5.1%-or More Decrease in Funding
Altruism: volunteering to take a cut or go without
Compassion: rescuing those who cannot support themselves/assisting weak and suffering
Absolute Inclusiveness: no matter how meager the available resources, all stakeholders will receive a share-sustaining complete participation

Operating Values:

Scenario I, Increased Funding
Beneficence: doing the good that we are able to do
Access: ensuring clients' access to services in greater numbers or more effective ways

Scenario II, Flat Funding
Access: ensuring clients' access to services in greater numbers or more effective ways
Representation: implementing decision-making in a way that includes people who adequately represent and/or reflect the need and diversity of constituencies involved
Quality of Care: the highest level of competence in providing care

Scenario III, .1-5% Decrease in Funding
Beneficence: doing the good that we are able to do
Access: ensuring clients' access to services in greater numbers or more effective ways
Non-maleficence: avoiding making the situation worse

Scenario IV, 5.1%-or More Decrease in Funding
Beneficence: doing the good that we are able to do
Access: ensuring clients' access to services in greater numbers or more effective ways
Survival: maintaining the existence of an organization or system of care

A. ***Justice Ethics***: *people have inherent equal rights; there are individual differences in capacity; community must strive to equalize opportunity; importance of rules of process; and there are winners and losers.*
   - Equality: equal portions to each or equal cuts
   - Equity: relatively equal portions with attention paid to severe need
   - Fairness: similar cases treated in a similar fashion
   - Altruism: volunteering to take a cut or go without
   - Compassion: rescuing those who cannot support themselves/assisting weak and suffering
   - Chance: fate decides through random choice; let the universe decide
   - Coercion: enforced decision by authority
   - Utilitarianism: greatest good for the greatest number
   - Rights and Duties: participation in community recognizes reciprocal rights and duties
   - Retributive Justice: making up for past inequities
   - Distributive Justice: working toward general equality
   - Merit: past or current contributions
   - Market: ability or willingness to pay
   - Fidelity: recognizing and adhering to past commitments

B. ***Caring Ethics***: *Based on the work of Carol Gilligan (In A Different Voice, Harvard University Press, 1982)—both need and capacity vary among individuals and over time; community must strive to meet different needs; community must take different capacities into account; and importance of complete inclusion.*
   - Absolute Inclusion: no matter how meager the available resources, all community participants will receive a share of resources. The goal here is to sustain complete participation.
   - Nuanced Inclusiveness: since there are real differences among participants regarding both need and abilities, a process for assessing these differences will be developed. This will allow for differential distribution while assuring complete participation.
   - Risk Equalization: one way to ensure participation by all is to share risk across all participants. This maintains traditional allocation while engaging all participants in efforts to increase resources

II. **Operating Values**: Resource allocation paradigms do not guarantee that the process of the decision will be or feel "ethical"—e.g., consistent with an individual's or a community's values. Besides choosing an overall ethical model, process values are necessary for a "just" outcome.
   - ***Openness or Transparency***: decisional processes are not secret but open for all to witness and for all interested parties to input
   - ***Good Citizenship***: focus on an individual's or an agency's responsibilities as a participant in the larger community
   - ***Efficiency***: accomplishing the desired operational outcomes with the least use of resources
   - ***Organizational Integrity***: a state of economic and structural stability, not a "moral" value
   - ***Survival***: maintaining the existence of an organization or system of care

- ***Contract Integrity***: an organization or funding body is as good as its word
- ***Quality of Care***: the highest level of competence in providing care
- ***Fidelity***: multiple commitments that bind funders and providers to the clients for the duration of need
- ***Advocacy***: the asymmetrical power relationship of provider and client requires the provider to take care to protect the client
- ***Beneficence***: doing the good that we are able to do
- ***Non-maleficence***: avoiding making the situation worse
- ***Access***: ensuring clients' access to services in greater numbers or more effective ways
- ***Representation***: implementing decision-making in a way that includes people who adequately represent and/or reflect the need and diversity of constituencies involved